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	295017	A. BUILDING _____ B. WING _____	09/25/2009

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F 000	INITIAL COMMENTS Surveyor: 26907 This Statement of Deficiencies was generated as the result of the 6 month Special Focus Facility Medicare re-certification survey conducted at your facility on 9/22/09 through 9/29/09, in accordance with 42 CFR Chapter IV Part 483 - Requirements for States and Long Term Care Facilities. The census at the time of the survey was 126. The sample size was 24 including 3 closed records. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	F 000		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Surveyor: 27206
Based on record review, policy review, and interview, the facility failed to ensure that the resident or their legal representative made an informed choice about the risks and benefits of psychopharmacological drugs for 1 of 24 residents (Resident #3).

Findings include:

Resident #3

Resident #3 was originally admitted to the facility on 11/5/08, with readmission on 4/22/09, with diagnoses including Parkinsons Disease, Dementia, Bipolar Disorder, and Hypertension. The Minimum Data Set (MDS) dated 6/8/09, revealed the resident had severely impaired

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F 157	Continued From page 2 cognitive skills for daily decision making. A public guardian for the resident was appointed on 3/25/09. Medication orders for Resident #3 included Ativan 0.5 mg four times daily for anxiety, Seroquel 25 milligrams (mg) three times daily for depression, and Depakote 1000 mg daily for mood. The resident's record revealed a verbal consent by the resident was taken by nursing for Seroquel on 4/22/09 and for Ativan on 9/15/09. There was no consent for Depakote. There was no documented evidence that the resident's guardian had been informed about these medication interventions. On 9/22/09 at 12:15 PM, the social worker, Employee #4, was interviewed. When asked about Resident #3's ability to understand the benefits and risks of psychopharmacological drugs, the social worker indicated that the resident's comprehension was limited to basic needs "like taking showers and having meals." The social worker further explained that informed consents were supposed to be signed by the guardian. In the facility's "Psychotropic/Psychoactive Drugs" policy, dated 7/2009, there was no reference made to obtaining consents from residents or their legal guardian. On 9/25/09 at 10:30 AM, the Administrator, Employee #1, acknowledged according to facility policy that a consent should have been obtained for Depakote and the facility should have obtained consents from the resident's guardian for the psychotropic medications.	F 157		
F 223	483.13(b), 483.13(b)(1)(i) ABUSE	F 223		

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The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

This REQUIREMENT is not met as evidenced by:
Surveyor: 13766
Based on observation, interview, and record review, the facility neglected to place pads on the siderails of a resident with a known history of traumatic brain injury with seizures for 1 of 24 residents (Resident #4).

Findings include:

Resident #4

Resident #4 was a 37 year old male admitted to the facility on 3/23/07 and readmitted on 6/08/09 with diagnoses to include Persistent Vegetative State due to a Traumatic Brain Injury from a Motor Vehicle Accident, Seizure Disorder, Gastrostomy Tube, Tracheostomy Tube and a History of Pneumonia.

During the inital tour on 9/22/09, Resident #4 was observed lying in bed in a supine position with his hands grasped closed. The resident was awake and his eyes were blinking. He responded to verbal stimuli.

Both side rails were observed up in the resident's bed. The resident's siderails and headboard were

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F 223	Continued From page 4 not equipped with padding. During all days of the survey on 9/22/09, 9/23/09 9/24/09 and 9/25/09 in the morning and afternoon Resident #4 was observed in bed with his siderails up. The siderails were not equipped with padding. On 9/25/09 in the afternoon, Resident #4's sister indicated she remembered the siderails of Resident #4 bed having pads, however she indicated had not been padded for a very long time. During the interview with the family on 9/25/09, Resident #4 first became rigid then he began jerking and flailing his arms and legs about. The resident's eyes rolled back and he began grimacing and drooling. The resident's closed fists began to strike the siderails of the bed continuously. Resident #4's brother-in-law tried to hold the resident's hands from striking the siderails and the resident's sister ran to get a staff member. A Certified Nurse's Assistant (CNA) entered the room with Resident #4's sister. Resident #4's sister indicated to the CNA, "He's having a seizure." The CNA indicated, "No, he does this all the time." Resident #4's brother-in-law was still holding the resident's hands so they would not strike the siderails of his bed. Resident #4's Comprehensive Care Plan dated 7/23/09 and 8/22/09, indicated the following documentation:	F 223		

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F 223	Continued From page 5 "...Problem/Need... -Resident has a history of seizures and is at risk for injury -Closed head injury Resident takes; -Phenobarbital -Ativan -Keppra" "...Goal... -Will be free of seizure activity over next 90 days -Resident will not sustain injury during seizure activity over next 90 days." "...Approach... -Monitor for signs of warning prior to seizure -Give meds (medications) per order, monitor labs--report abnormal labs to MD -Protect resident from injury if seizure occurs -Ensure direct care staff are aware of resident's history -Pad siderails as needed to prevent injury -Document seizure activity" Resident #4's Phenobarbital Level laboratory result dated 5/15/09, measured 12.1 (normal value 15.0-40.0 mcg/ml (micrograms per millileter). On 9/25/09 a Phenobarbital level was drawn after the episode. Resident #4's Phenobarbital level measured 10.2 (normal 15.0-40.0). The facility Policy and Procedure for seizure precautions was taken from, Perry and Potter Nursing Procedures (update unknown) entitled Skill 4-4. The policy indicated the equipment necessary equipment for a patient on seizure precautions included: -Oral airway	F 223		

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F 223	Continued From page 6 -Padding for siderails and headboard -oral suction equipment -clean disposable gloves.	F 223		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 21794 Based on observations, the facility failed to ensure the catheter bag was covered for 1 of 24 residents (Resident #9) and staff were seated while assisting residents during meals. Findings include: 1. Resident #9 Resident #9 was a 25 year-old male initially admitted to the facility on 11/1/07 and readmitted on 7/22/09, with diagnoses including Anxiety State Not Otherwise Specified, Depressive Disorder, Chronic Pain, C1 - C4 Complete Quadriplegic, Esophageal Reflux, Bladder Calculus, Neurogenic Bladder, Bladder Disorder, Status Post Urinary Tract Infection, Contractures, Insomnia and Spasm of Muscle. During the initial facility tour on 9/22/09, the resident's Foley catheter bag was visible from the corridor and was not covered to maintain the resident's dignity. Surveyor: 26907	F 241		

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F 241	Continued From page 7 2. On 9/22/09 at 11:30 am, during the lunch meal in the resident assist dining room, two Certified Nursing Assistants and two nursing staff were observed standing while feeding residents.	F 241		
F 248 SS=D	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 27206 Based on observation, record review, and interviews, the facility failed to provide an ongoing program of activities designed to meet a resident's interests in accordance with the comprehensive assessment for 1 of 24 residents (Resident #3). Findings include: Resident #3 Resident #3 was originally admitted to the facility on 11/5/08, with readmission on 4/22/09. The resident's diagnoses included Parkinsons Disease, Dementia, Bipolar Disorder, and Hypertension. The Minimum Data Set (MDS), dated 6/8/09, revealed the resident needed extensive to total assistance with his Activities of Daily Living (ADLs). Resident #3's Activities care plan revealed the following problem: "Requires in-room activities; is	F 248		

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at risk for decreased socialization due to being bedfast." The following individualized approaches were listed: "1) Turn on radio or TV for sound stimulation; 2) Rub lotion on hands and arms; 3) Read to him, provide magazines for him." The last review date of the care plan was 9/4/09.

On 6/5/09, the Activities Director, Employee #3 noted the following in the activities progress notes: "He continues to spend much of the time in bed and requires staff to provide room visits for social stimulation such as turn on Spanish radio or TV."

During the survey period on 9/23/09, it was observed that Resident #3 did not have a TV in his room. Two nurses confirmed they had not seen a TV in the resident's room for six weeks. The Activities Director acknowledged being unaware the TV was missing.

On 9/24/09 at 12:30 PM, a CNA, Employee #8, was asked how the resident felt about having a TV. The CNA responded, "He always asks to watch TV. He likes watching the church programs in Spanish."

The Activities Director brought a TV to Resident #3's room on 9/25/09. The TV channels were not working, but videos could be played. The Activities Director explained that in order to obtain TVs for residents, donations were requested from the community or from a guardian. When asked if Resident #3's public guardian was asked about donating a TV, the Activities Director acknowledged that he had not considered that option. After a movie was started, the resident was asked if he liked it, and he responded, "It's good. I like the movie. Thank you."

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F 252 SS=E	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Surveyor: 25282 Based on observation and interview, the facility failed to provide a clean environment. Findings include: 1. On 9/23/09, 7 of 10 residents in the group interview indicated that the vents in their rooms were filthy. 2. On 9/24/09, the following areas were observed with dirty air vents: - C Hall shower room, laundry area, central supply room. - Rooms Numbers; 6, 8, 28, 32, 29. 30, 31, 59, 60, 67,61, 67, 63. Surveyor: 13766 3. During the initial tour on 9/22/09 in the morning: - The bathroom in room 29 shared by four residents had a dirty brown towel wrapped around the base of the toilet bowl. The toilet seat contained yellow urine-like stains as well as the floor. There was toilet tissue strewn on the floor. Under the sink contained a brown substance running down the wall.	F 252		

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F 252	Continued From page 10 - The bathroom in room 30 shared by four residents smelled of old urine. The floor contained urine-like yellow stains. There were several sputum-like stains in the washbasin of the sink. The rim of the toilet bowl had dark brown stains.	F 252		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Surveyor: 13766 Based on observation, interview and record review, the facility failed to ensure care plans were developed and followed to maintain the resident's highest practicable medical, physical	F 279		

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and psychological well being for 2 of 24 residents (Residents #4, #5).

Findings include:

Resident #4

Resident #4 was a 37 year old male admitted to the facility on 3/23/07 and was readmitted on 6/08/09 with
diagnoses to include Persistent Vegetative State due to a Traumatic Brain Injury from a Motor Vehicle Accident, Seizure Disorder, Gastrostomy Tube, Tracheostomy Tube and a History of Pneumonia.

During the inital tour on 9/22/09, Resident #4 was observed lying in bed in a supine position with his hands grasped closed. The resident was wake and his eyes were blinking. He reponded to verbal stimuli.

The resident had both side rails up in the bed. The resident's siderails and headboard were not equipped with pads.

During all days of the survey on 9/22/09, 9/23/09 9/24/09 and 9/25/09 in the morning and afternoon Resident #4 was observed in bed with his siderails up. The siderails were not equipped with pads.

On 9/25/09 in the afternoon, Resident #4's sister indicated she remembered the siderails of Resident #4's bed having pads, however she indicated it had not been for a very long time.

Resident #4's Comprehensive Care Plan dated 7/23/09 and 8/22/09, indicated the following

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documentation:

"...Problem/Need...
-Resident has a history of seizures and is at risk for injury
-Closed head injury
Resident takes:
-Phenobarbital
-Ativan
-Keppra"

"...Goal...
-Will be free of seizure activity over next 90 days
-Resident will not sustain injury during seizure activity over next 90 days."

"...Approach...
-Monitor for signs of warning prior to seizure
-Give meds (medications) per order, monitor labs--report abnormal labs to MD
-Protect resident from injury if seizure occurs
-Ensure direct care staff are aware of resident's history
-Pad siderails as needed to prevent injury
-Document seizure activity"

The facility did not ensure the Comprehensive Care Plan for Resident #4 was followed as documented.

Surveyor: 26907
Resident #5

Resident #5 was a 68 year old female originally admitted to the facility on 7/2/09 and was readmitted on 8/9/09 with diagnoses including Diabetes, Hypertension, Cerebral Vascular Accident, Right Hemiparesis, Dementia, Seizure Disorder, and Recurrent Urinary Tract Infections.

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F 279	Continued From page 13 Physician's orders dated 8/10/09 indicated "Seizure Precautions." Resident #5's care plan dated 8/12/09 included: - "RAP/Problem/Need - Resident requires the use of Padded Side Rails and is at risk for injury as evidenced by - Seizure Disorder. -Approach - 1) Assess the use of padded siderails q (every) 3 months and PRN (As Necessary); 2) Inform staff of the use of padded side rails." On 9/22/09. during the initial tour and throughout the survey, Resident #5 was observed lying in bed with 1/2 siderails up. There was no padding on the siderails or the headboard.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 25282 Based on interview and record review the facility failed to provide necessary care and services to maintain appropriate care for 2 of 24 sampled residents (#1, #15). Findings include: Resident #1	F 309		

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F 309	Continued From page 14 Resident #1 was originally admitted to the facility on 7/25/09 and was readmitted on 9/11/09, with diagnoses of End Stage Renal Disease and Extracorporeal Dialysis. The physician's order dated on 9/14/09, indicated hemodialysis to be done every Monday, Wednesday and Friday. The medical records documented Resident #1 had inhouse hemodialysis treatments on 9/14/09, 9/16/09, 9/18/09, 9/21/09 and was observed receiving treatment on 9/23/09. The inhouse Hemodialysis was conducted by a licensed contracted company which monitored and assessed the resident during dialysis treatment. The Hemodialysis treatment records for the days of dialysis treatment had an area to document pre and post dialysis weight. This area was marked with N/A (not applicable) on each dialysis treatment record. An interview with staff on the morning of 9/25/09, revealed the facility staff were supposed to weigh Resident #1 pre and post dialysis treatment. The staff member further indicated that pre and post weights were found on the back of the nurse's summary sheets. There was no documented evidence in the medical record that Resident #1 was weighed pre and post dialysis treatment. Resident #15 Resident #15 was originally admitted to the facility on 8/8/09 and readmitted on 8/22/09, with a diagnosis of End Stage Renal Disease. The	F 309		

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F 309	Continued From page 15 physician's order dated on 8/22/09, indicated inhouse dialysis treatment on Monday, Wednesday and Fridays. The medical records revealed inconsistent assessment of pre and post dialysis weight for Resident #15. There were missing pre and post weights for dialysis treaments on 9/11/09, missing pre weight on 9/14/09 and missing pre weight on 9/16/09.	F 309		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Surveyor: 26907 Based on record review and interview, the facility failed to ensure medical justification for a Foley catheter for 1 of 24 residents (Resident #5). Findings include: Resident #5 Resident #5 was a 68 year old female originally admitted to the facility on 7/2/09 and readmitted on 8/9/09 with diagnoses including Diabetes, Hypertension, Cerebral Vascular Accident, Right	F 315		

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Hemiparesis, Dementia, Seizure Disorder, and Recurrent Urinary Tract Infections.

Documentation in the nurse's notes revealed Resident #5 was readmitted on 8/9/09 with a Foley catheter. The catheter was discontinued on 8/10/09 due to no justification.

On 8/15/09 results of Resident #5's urine culture & sensitivity (c&s) showed the urine contained Klebsiella Pneumoniae, resistant to all antibiotics. Resident #5 was placed on antibiotics and an Infectious Disease (ID) consult was obtained.

The ID consult was completed on 8/17/09 which indicated the resident was incontinent of urine, asymptomatic, with urinary tract infection (UTI) versus colonization. The ID recommendations included:
"- At this time I would not recommend antibiotics
- If the resident develops a fever, obtain a CBC (Complete Blood Count) before instituting antibiotics
- Contact lab (laboratory) to obtain sensitivities for colestin...
- Obtain a urinalysis & urine c&s (culture and sensitivity) by catheterization
- Contact isolation is strongly recommended
- Before discontinuing isolation obtain weekly rectal swabs. If 2 consecutive samples are negative, then isolation may be discontinued."

Nurse's notes dated 8/17/09, indicated Resident #5 was placed on Contact Isolation. Subsequent nurse's notes through August and until September revealed Resident #5 continued on Contact Precautions and antibiotics for UTI.

Doctor's orders dated 9/13/09, indicated :

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F 315	Continued From page 17 - "Insert F/C (Foley Catheter) for socialization - D/C (Discontinue) Isolation" Nurse's notes dated 9/13/09, indicated, "Orders received to place Foley cath for out of room socialization & (and) to repeat urine c&s..." Nurse's notes dated 9/22/09, revealed the Foley catheter was discontinued. On 9/24/09 in the afternoon, the attending physician stated the Foley catheter was not inserted for "socialization," the catheter was inserted for colonization.	F 315		
F 318 SS=G	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Surveyor: 13766 Based on observation, interview, record review, and document review, the facility failed to ensure treatments and services were provided to prevent further decrease in range of motion for 2 of 24 residents (Residents #4, #9). Findings include: Resident #4 Resident #4 was a 37 year old male admitted to	F 318		

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the facility on 3/23/07 and was readmitted on 6/08/09 with
diagnoses to include Persistent Vegetative State due to a Traumatic Brain Injury from a Motor Vehicle Accident, Seizure Disorder, Gastrostomy Tube, Tracheostomy Tube and a History of Pneumonia.

During the initial tour on 9/22/09, Resident #4 was observed lying in bed in a supine position with his prone hands grasped closed and contracted. The resident was awake and his eyes were blinking. He responded to verbal stimuli. The resident's right extremity was noted to have a foot drop.

The Director of Rehabilitation (Rehab) indicated on 9/24/09 in the morning, that Rehab made rounds every morning to evaluate the needs of the residents. She added nursing staff could make recommendations if there was a need for a resident. The Director was asked about Resident #4's foot drop of his right leg. She indicated she was going to ask the physician about an order for a brace for his leg.

On 9/23/09, an interview with Resident #4's brother indicated he had been asking for something to be done with the resident's hands because he noticed the hands were always in a fist and had not seen them opened. During the family interview, the Certified Nursing Assistant (CNA) caring for Resident #4 was asked what was done for the resident's hand contractions. The CNA replied, "a washcloth is rolled up and placed in both hands." The resident's brother indicated he had never seen the washcloths in Resident #4's hands.

The facility's Policy and Procedure- Subject

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F 318	Continued From page 19 Contracted Hand Care revised 2009 indicated the following: "9. Place a hand roll in the palm of the hand. ...NOTE: A special hand roll or splint type device is used as indicated in the care plan." There was no documentation in Resident #4's Care Plan indicating the staff performed range of motion exercises or used assistive devices to prevent the resident from further decline. Surveyor: 21794 Resident #9 Resident #9 was a 25 year-old male initially admitted to the facility on 11/1/07 and readmitted on 7/22/09, with diagnoses including Anxiety State Not Otherwise Specified, Depressive Disorder, Chronic Pain, C1 - C4 Complete Quadriplegic, Esophageal Reflux, Bladder Calculus, Neurogenic Bladder, Bladder Disorder, Status Post Urinary Tract Infection, Contractures, Insomnia and Spasm of Muscle. A Physician Telephone Order, dated 7/10/09, noted an order for Occupational Therapy to assess the resident for a "Brace for Arm." The resident's record revealed no documented evidence the resident received an Occupational Therapy assessment for a brace to his upper extremities. During the re-certification survey, the resident was observed without a brace on either arm. On 9/24/09 at 9:20 AM, the resident stated, "I thought they wrote an order for the braces." The	F 318		

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F 318	Continued From page 20 resident indicated he had not received an evaluation for the braces nor received the braces.	F 318		
F 321 SS=D	483.25(g)(1) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable. This REQUIREMENT is not met as evidenced by: Surveyor: 13766 Based on observation, interview and record review, the facility failed to ensure a resident's condition warranted the use of a gastrostomy tube for 1 of 24 residents (Resident #21). Findings include: Resident #21 Resident #21 was a 66 year old male admitted to the facility on 9/27/04 and was readmitted on 11/01/08 with diagnoses to include Kidney Stones, General Muscle Weakness, Diabetes, Traumatic Brain injury due to an assault and Attention to Gastrostomy Tube. During the initial tour on 9/22/09 the MDS (Minimum Data Set) Coordinator indicated Resident #21 had a Gastrostomy Tube (GT). She indicated the resident ate and the GT was used for medications, however the resident was able to take his medications orally: - Resident #21 was observed on 9/23 and 9/24/09 eating breakfast and lunch. He was also observed	F 321		

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F 321	Continued From page 21 taking his medications by mouth. An Assessment Plan note from Dietary dated 4/1/09 indicated, "Res (resident) eats well. Resident shows some non-significant but desired decline. Res still has a G-tube in place. Unknown of what came from GI (gastrointestinal) consult for peg removal." On 6/20/09, notes indicated, (Resident #21) "continues to eat 100% of meals and receives only water flushes through his tube." Nutritional Notes dated 8/21/09, indicated the resident continued to eat orally and only medications were given through the G-Tube. On 9/24/09, the Dietary Manager indicated she made a recommendation to have the G-tube removed from Resident #21 in April 2009 because the resident was eating a full diet and the risk of infection outweighed the benefits of keeping in the G-tube. On 9/24/09 in the afternoon, Resident #21's physician indicated he was trying to get a GI (gastrointestinal) consult for several residents to have their G-tubes removed. He indicated it was very difficult to get specialists to come in to see the residents. He further indicated Resident #21 should probably have his G-tube removed since he was eating well and was overweight.	F 321		
F 325 SS=G	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels,	F 325		

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F 325	Continued From page 22 unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Surveyor: 27206 Based on observation., interview, record review, and document review, the facility failed to ensure acceptable parameters of body weight were maintained resulting in significant weight loss for 2 of 24 residents (Residents #18, #3). Findings include: Resident #18 Resident #18 was originally admitted to the facility on 4/10/09, with readmission on 5/5/09. The resident's diagnoses included Cerebrovascular Disease with Left-sided Hemiparesis, Diabetes, Hypertension, Dysphagia, and Hypothyroidism. The resident was admitted with a gastrostomy tube (G-tube), and was receiving a mechanical soft, reduced concentrated sweets diet with nectar thickened liquids. The resident also had an order to add two cans of Glucerna supplement via G-tube if less than 50% of meals were consumed. Resident #18's weight on 4/11/09 was 181.8 pounds (lbs). When he was readmitted to the facility on 5/6/09 after a short hospital stay, his weight was 175.2 lbs. On 7/14/09, the resident's weight was 154.6, representing a 11.7% weight loss over a 3-month period.	F 325		

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The Nutrition Services Director (NSD), Employee #5, who was also a Dietetic Technician, made a recommendation to change the order from as-needed G-tube bolus feedings to three G-tube bolus feedings daily for 1706 calories per day. The order was implemented on 7/14/09. Record review revealed the facility's Consultant Dietitian, Employee #6, reviewed the order made by the NSD on 7/15/09.

On 7/23/09 the NSD recommended adding a G-tube feeding at night for an additional 768 calories. This order was implemented on 7/23/09 and was reviewed by the dietitian on 7/28/09.

During the month of August a restorative aide (RA), Employee #7, observed Resident #18 for two meals daily. On 8/24/09 the RA, documented, "Resident continues to try to feed self...Resident usually eats 50-70% of meals." A review of the resident's meal intake record, however, revealed that the resident was actually consuming 25-50% of his meals.

The NSD was interviewed on 9/24/09 at 1:30 PM. The NSD indicated that, as a result of the RA notes, and because Resident #18's weight had increased to 162 lbs, she made the decision to discontinue the three daily G-tube feedings, keeping as-needed G-tube bolus feedings. The NSD also changed the resident's care plan approach from offering tray set-up and assisting with verbal cueing to "assist with meals as needed."

On 9/1/09 Resident #18's weight was 163.4 lbs, and weekly weights were discontinued. Because the resident was to receive G-tube feedings if

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meal intake was less than 50%, Certified Nursing Assistants (CNAs) in the dining room maintained meal intake information, and this information was then documented on the Medication Administration Record (MAR) by nursing staff.

Review of the resident's meal intake records and MAR for the month of September revealed many inconsistences. For example, on 9/14/09, the meal intake record indicated the resident consumed 25% of his dinner meal, whereas the MAR indicated 50% for the same meal. For the month of September, there were 16 instances whereby CNAs in the dining room documented that the resident ate less than 50% of his meals, but the MAR indicated the resident ate more than 50% of those same meals. Nursing, then, would not have provided Resident #18 with his G-tube supplemental feeding for those meals because of these discrepancies. There was also no way to determine on the MAR, if any G-tube feedings were ever given to the resident, as nursing did not document the feedings.

On 9/24/09 at 7:15 AM, Resident #18 was observed in the RA dining room at a table by himself. The resident was reclined in his wheelchair and his breakfast tray was out of reach from where he was positioned. From 7:15 AM to 7:30 AM, no staff came to assist the resident, and the resident was observed to nod off to sleep. At 7:30 AM Resident #18 was observed to struggle to reach his tray and then take two bites of his cold cereal. A CNA then approached the resident and asked if he was done. The resident responded yes and The CNA took his tray away. For that breakfast, the CNA documented that the resident ate 25% of his meal. For the same meal, it was recorded on the

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resident's MAR that 50% of the meal was consumed.

On 9/24/09, a requested weight for Resident #18 revealed the resident was 153 lbs. This was a 10 lb (6%) weight loss since the last time the resident's weight was taken on 9/1/09, when it was recorded that the resident weighed 163.4 lbs.

According to the facility's Weight Protocol policy, provided by the NSD and dated 3/8/07, "A significant weight change is identified as: more than 5% in one month; the physician and responsible party to be notified of significant weight changes by nursing staff."

Both the NSD and the consultant dietitian acknowledged they were unaware of Resident #18's recent significant weight loss and there was no documented evidence that the resident's physician had been notified of this weight loss.

Review of the facility's Nutrition Policies and Procedures, dated 7/2009, revealed the NSD was to refer residents at nutritional risk to the registered dietitian for nutritional assessment according to the following guidelines, including a significant unplanned weight change of more than 5% in 30 days, and new or changed orders for enteral feeding. According to the policy, "The NSD only collects data and documents a preliminary review of nutritional status...The DTR may additionally summarize and document comparison of findings to standards and may make recommendations for diet change or additional interventions as needed...The Registered Dietitian prepares a list of clinical recommendations at each visit to notify nursing and/or physicians of recommendations,

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suggestions, or requests in regard to the nutritional care of the resident."

Record review indicated that while the consultant dietitian reviewed diet change recommendations by the facility's NSD, the dietitian did not write the diet orders herself per facility policy.

On 9/25/09 at 10:45 AM, the dietitian was interviewed. The dietitian reported that the NSD wrote the diet orders for Resident #18, and that she confirmed the orders when she came to the facility. Resident #18's weight loss of 10 lbs over the past three weeks was brought to the dietitian's attention. The dietitian acknowledged that whenever a diet order was changed, weights should be monitored with a calorie count.

Resident #3

Resident #3 was originally admitted to the facility on 11/5/08, with readmission on 4/22/09, with diagnoses including Parkinsons Disease, Dementia, and Hypertension. Upon admission, the resident's weight was 165.4 lbs. When he was discharged from the facility on 2/14/09, he weighed 131.8, a 20% weight loss in four months. Before returning to the facility, the resident received a G-tube. Upon readmission, the resident weighed 136.6 lbs. On 9/1/09, he weighed 121.6 lbs, an 11% weight loss in 4.5 months.

Review of Resident #3's record revealed that the resident refused to to be fed by G-tube, and that his meal intake was variable. According to physician's orders, the resident was to be receiving a mechanical soft diet with Enlive nutritional drink and pudding with every meal. On

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9/23/09 at breakfast and on 9/24/09 at lunch it was observed that the resident's meal trays did not include these two supplemental foods. It was also observed that the resident's meal ticket did not list the ordered pudding. The meal ticket included two ounces of salsa, but this was also not provided.

Through a CNA, serving as an interpreter, Resident #3 was asked on 9/23/09 at 8:30 AM about his favorite foods. The resident reported that he liked rice, strawberry ice cream, and beans.

On 9/23/09 at 9:00 AM, the Nutrition Services Director (NSD) acknowledged that the kitchen was out of the Enlive drink. The NSD could not explain why the order for pudding, made on 4/23/09, had not been inputted into the facility's diet software program. When asked about residents' food preferences, the NSD indicated that specific foods, such as strawberry ice cream and beans, were not ordered if they were not a part of the planned menu, and that, while food preferences were documented upon admission, this information was not available in the software program.

The facility's Nutrition Policies and Procedures, dated 7/2009, included the following procedures: "1) A diet change will be ordered by the physician, recorded on the physician's orders, and implemented by the Nursing and Nutrition departments; 2) Nutrition Services will update the resident's tray ticket or computerized profile to reflect the new order; 3) The diet order in the medical record agrees with the resident profile, the tray identification ticket, and menus planned on the extended menu. The NSD or designee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295017	A. BUILDING _____ B. WING _____	09/25/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT LANE CARE CENTER	660 DESERT LANE LAS VEGAS, NV 89106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 28 audits these areas for consistency at least monthly; 4) Keep food preferences updated so that residents do not continually receive foods they will not or cannot eat."	F 325		
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 27206 Based on observation, policy review, and interview, the facility failed to ensure food was prepared and distributed under sanitary conditions. Findings include: An inspection of the facility's kitchen and premises on 9/22/09 revealed the following: Improper food handling: At 8:20 AM, a box of uncooked bacon and a box of sliced ham were observed on a cart. A cook reported that the boxes were brought out of the freezer at 6:30 AM. A temperature check revealed that the bacon was 57.2 degrees Fahrenheit (F) and the ham was 58.7 degrees F. The facility's "Safe Food Handling" policy, dated 8/2008, indicated that cold foods were to be maintained at 40 degrees F or	F 371		

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F 371	Continued From page 29	F 371		

below. At 9:15 AM, a carton of Sysco Med Plus high calorie supplement drink was observed sitting at room temperature on a med cart. A date of 9/22/09 was written on the carton, indicating when it was opened. A temperature check revealed the drink was 68.8 degrees F. The manufacturer's instructions on the carton indicated the following: "Contains milk and soy ingredients. Serve chilled. Refrigerate after opening."

Inadequate sanitizing solution: There was no evidence of a sanitizer in the wiping cloth bucket solution.

Improper garbage disposal: At 2:30 PM, an outside bin was observed to be filled to the top with large bags of garbage, and one of the bags was on the ground. In an interview at 3:00 PM, the maintenance supervisor indicated that that the garbage bags in the bin were supposed to be transferred every hour to the nearby waste compressor.

An inspection of the facility's kitchen was conducted by the sanitarian on 9/23/09, and the following findings were listed on the Food Service Establishment Report:
1. There were three dented cans of soup in dry storage.
2. The hose attached to the three-compartment sink faucet was damaged.
3. Staff restrooms near the kitchen had peeling paint on walls and dirty floors.
4. There was inadequate lighting in dry storage, and a burned-out hood light.
5. The janitor closet/surplus storage area had maintenance items stored next to back-up kitchenware.

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F 371	Continued From page 30 6. The interior plastic panel of the ice machine and the door of the ice machine were damaged. 7. The gaskets on the reach-in freezer were damaged. 8. The copper drain line in the walk-in refrigerator was exposed and in need of painting. 9. The toaster was improperly stored on a bedside table.	F 371		